Please complete and return to: **Insure Montana**
840 Helena Avenue
Helena, MT 59601
Fax: 406-444-3435

INSURE MONTANA

TAX CREDIT PROGRAM CHANGE REPORT

Effective Date of Change: _____

Business Name: _____

Employee Name: _____ Age: _____

Insurance Agent Name: _____

TYPE OF CHANGE

____New employee (must complete information below)

____Delete employee and all dependents; (effective date): _____

____Add spouse/dependent(s) (must complete information below)

____Delete spouse/dependent(s); (effective date): _____

____Change in health insurance coverage: _____
_____

____Other (explain): _____

Comments:_____
_____
_____

NEW EMPLOYEE CHANGES

Employee Name: _____
Social Security No.: _____
Date of Birth: _____
Date added to coverage: _____
Employee Monthly Premium: $_____
Business Contribution per Month: $_____

Amount Business Contributes
for Spouse per Month: $_____
Date Spouse Added: _____
Amount Business Contributes for Dependent(s)
per Month: $_____
Number of Dependents: _____
Date Dependent(s) Added: _____

NOTE: Do not count a spouse as a dependent.

CERTIFICATION AND SIGNATURE

I certify, under penalty of law, that all my answers are correct and complete to the best of my knowledge. I understand the penalty for withholding or giving false information which may include a possible criminal offense (MCA 33-22-2009). I agree to provide documents to verify information on this form if requested. I understand that State staff may obtain documents and/or information to verify statements on this form.

Signature:_____**Date:**_____

*Forms and other pertinent information can be found on the Insure Montana website at: *insuremontana.org*